11-0900-20945-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Auburn Home in Waconia;
Survey Exit Date September 10, 2009

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Barbara L. Neilson on January 19, 2010. The OAH record closed at the conclusion of the conference that day.

Marci Martinson, IIDR Coordinator, Licensing and Certification Program, appeared on behalf of the Department of Health's Division of Compliance Monitoring (Department). Mary Cahill, Planner Principal with the Division of Compliance Monitoring, also participated in the conference. Susan M. Schaffer, Attorney at Law, appeared on behalf of Auburn Home in Waconia (Facility). Kirsten McGowan, Assistant Administrator and Director of Nursing; Lynn Haering, Social Service Director; and Wayne Ward, Facility Administrator, also participated.

NOTICE

In accordance with Minn. Stat. § 144A.10, subd.16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

Tag F 319 is supported by the facts and should be affirmed, but the scope and severity level should be reduced to level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy).

Dated: February 2, 2010.

s/Barbara L. Neilson
BARBARA L. NEILSON
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared).

MEMORANDUM

Introduction

In September 2009, a surveyor for the Department of Health and Human Services Centers for Medicare and Medicaid Services conducted a standard survey at the Facility in Waconia, Minnesota. On or about October 6, 2009, the surveyor issued a Summary Statement of Deficiencies to the Facility that included a citation for a violation of Tag F 319 (quality of care, mental and psychosocial functioning). The violation was cited as a G-level deficiency, based upon the surveyor's conclusion that the deficiency was isolated in scope with a severity level of actual harm that is not immediate jeopardy.[1] Before deciding that the violation occurred, the surveyor reviewed records and interviewed the Facility's Social Services Director. She did not discuss the situation with any other Facility staff or with the Resident's family members.

In this IIDR proceeding, the Facility disputes this citation and asserts that it should be removed; or in the alternative, that the severity level should be reduced from G-level (actual harm) to D-level (no actual harm with potential for more than minimal harm that is not immediate jeopardy).

Factual Background

Resident #62 (Resident) was a 93-year-old man who was admitted to the Facility on May 6, 2009, following a period of hospitalization for a heart attack and congestive heart failure. Before his hospitalization, the Resident lived independently in an assisted-living apartment. He hoped to return to the apartment after a short-term stay at the Facility. In addition to the congestive heart failure, the Resident had diagnoses including senile dementia, anxiety disorder, chronic pain, malaise, fatigue and nutritional deficiency.[2] On May 5, 2009, before the Resident was moved from the hospital to the Facility, his doctor noted in his chart that the Resident was "looking forward to death" and that the plan was to "treat for comfort."[3]

The Facility completed an initial Minimum Data Set (MDS) on May 19, 2009. The MDS indicated that the Resident had memory problems and moderately impaired decision-making skills, as well as altered perception or awareness of surroundings and periods of restlessness. The MDS also reflected that the Resident had anxious complaints that were not easily altered.[4] A Resident Assessment Protocol (RAP) dated May 19, 2009, indicated concerns requiring a Care Plan for mood state but not for psychosocial well-being.[5] The RAP summary stated that the Resident was "anxious" with a history "of depression and anxiety." The May 19 RAP noted that staff reported

[1] MDH Ex. E.
[2] MDH Ex. E-2.
[3] Facility Ex. 14.
[4] Facility Ex. 2.
[5] Facility Ex. 2.

the Resident was "calm, talkative" and "joking with staff." In addition, the Resident stated he was willing to attend activities at the Facility.[6]

On May 7, 2009, the Resident stated to Facility staff that "he is very social and will need time to adapt to another change . . ." Later that day, the Resident appeared anxious, asking "How did this happen to me?" On May 11, 2009, nursing notes indicated that the Resident was moderately confused. On May 12, 2009, the Resident was noted to be "preoccupied with death." Later in May, the nursing notes stated that the Resident was continuing to make statements wishing he was dead, or wondering why he did not just die. Ativan was prescribed for the Resident and was generally noted to be effective in calming him when he was anxious.[7]

Following a May 26, 2009, Care Conference, the Facility developed a Care Plan for the Resident. The Care Plan included a number of measures to address problems with "ineffectual coping r/t [related to] multiple life changes, memory loss, and impaired problem solving skills, pain." The Care Plan directed nursing staff to assist the Resident in establishing relationships with staff and other residents. It also stated that Facility staff should determine the Resident's needs and provide for them, if possible; help the Resident understand what to expect and give him choices; allow the Resident time to express sadness and anger; provide medication to the Resident according to doctor's orders; and assist the Resident with phone use for communication with family and friends and for chaplain visits as needed.[8]

At the end of May, the Resident's affect was described as "flat." On June 1, 2009, the Resident was described as "very depressed" with increased confusion, crying, sad facial expressions and anxiousness.[9]

On June 3, 2009, the Resident's physician and daughter agreed that the Resident needed long-term-care placement. The Resident was moved to the long-term care area of the Facility on June 10, 2009.[10]

Notes in July and August described the Resident as anxious, agitated, angry, unhappy and morose.[11] The Resident's physician (who has known the Resident for an extensive period of time) visited the Resident at least eight times during the three months the Resident lived in the Facility, had ongoing contact with staff, and made adjustments to his medications throughout that time (sometimes at the request of Facility staff).[12]

A Social Service Assessment was competed regarding the Resident on August 11, 2009. The assessment stated that the Resident had generalized apathy; periods of depression and sadness; cried easily and had a low energy level; did not accept his

[6] Facility Ex. 3.
[7] MDH Ex. E-2.
[8] Facility Ex. 4.
[9] MDH Ex. E-3.
[10] MDH Ex. E-3.
[11] MDH Ex. E-3.
[12] Facility Exs. 7, 8, 13.

need to be placed in the Facility; focused on negative feelings only; was aware of his physical condition but had not accepted limitations; was suspicious; was anxious, fearful, insecure; and had unresolved issues regarding loss of money, property, or possessions. The assessment indicated under "Behaviors and Counseling Needs" that the Resident was suffering from depression and anxiety, and identified under "Additional Assessment Tools" that a Depression Scale should be conducted.[13] There is no evidence that any follow-up occurred regarding either of these identified needs before the Resident's death five days later.

A RAP Summary relating to the Resident was completed on approximately August 12, 2009. The RAP Summary indicated that the Resident had a history of depression and anxiety and noted that the Resident's physician had mentioned "Sundowners" syndrome in his last note. It also stated that the Resident "gets angry with staff and redirection daily" and that the Resident was "swearing" and "very anxious when attempting to talk." The RAP Summary noted that "calm reassurance and redirection effective." The summary indicated that the Facility would proceed with a care plan due to the Resident's history of depression and anxiety with medication use, confusion, and loss of autonomy.[14]

A second MDS was completed on approximately August 14, 2009. This MDS indicated an increase from "0" (not exhibited in last 30 days) to "1" (indicator exhibited up to five days per week) for negative statements; repetitive questions and verbalizations; persistent anger with self or others; self deprecation; expressions of what appeared to be unrealistic fears; recurrent statements that something terrible was about to happen; repetitive health complaints; repetitive anxious complaints and concerns; unpleasant mood in morning; insomnia/changes in usual sleep pattern; sad, pained, and worried facial expressions; crying and fearfulness; repetitive physical movements; withdrawal from activities; and reduced social interaction. The MDS also indicated that one or more indications of depressed, sad, or anxious mood were present but not easily altered by attempts to cheer up, console, or reassure the Resident. The MDS concluded that the Resident's mood status had deteriorated during the past 90 days and noted that that a RAP had been triggered with respect to psychosocial well-being, mood state, and behavioral symptoms (as well as other problem areas).[15]

The Resident died on August 16, 2009, following a period of declining activity in early August and no activity for the last three days of his life.[16] His physician's notes dated August 13 indicated that the Resident was unable to communicate and was failing rapidly.[17] The Statement of Deficiencies indicated that the Social Services Director told

[13] Facility Ex. 19 and MDH Ex. E-4. The Summary Statement of Deficiencies states the 8/11/2009 social service assessment was dated four months after the Resident was admitted to the Facility. This is an error – the social service assessment was dated just over three months after the Resident was admitted to the Facility.
[14] Facility Ex. 6.
[15] Facility Ex. 5.
[16] Facility Ex. 7.
[17] Facility Ex. 13

the surveyor that Facility staff was "very surprised when the resident died, because he died rather quickly."[18]

The Resident's Activity Attendance calendar indicates that, between his admission on May 6 and his death on August 16, 2009, the Resident attended religious or spiritual activities at least twenty times. He was frequently visited by friends, family members, his priest and members of his church.[19] In addition, staff engaged him in one-to-one conversations and attempted to allay his anxiety and anger, but were only sometimes successful.[20] The Resident attended other activities at the Facility such as bingo, exercise, music and cognitive activities approximately on 10 occasions in May, 18 occasions in June, 17 occasions in July, and 9 occasions in August. Finally, the Facility chaplain visited with the Resident frequently, although he did not document his visits because he was concerned that to do so would violate the Resident's privacy.[21]

The Auburn Home administrator explained that the Facility is operated by Moravian Care Ministries. It opened in June 2008 and replaced an older facility that was called Auburn West. He indicated that the new Facility reflects a new philosophy of care. It consists of three "households," two with 12 long-term beds each and a third with 13 short-term beds. Each household has its own dining room and living room with dedicated nutrition, nursing and maintenance staff. Staff are encouraged to work across functional lines, within the limits of their licenses. For example, administrators may help residents to their tables and chat with them as they eat, maintenance staff may take time to talk with residents, and nurses may help with serving meals and cleaning tasks. Individual residents are supported in making their own choices, such as when to get up, go to bed, and eat breakfast. Because of this approach, social services are provided to residents in many different forms by different people.

The Director of Nursing stated that daily and weekly assessments are conducted for all residents on an ongoing basis. There are 15-minute standup staff meetings every day where day-to-day concerns are discussed. In addition, managers hold weekly interdisciplinary team meetings to discuss important events and to assess the needs of the residents. Decisions made at these meetings are translated into changes to individual residents' care plans. The Director of Nursing stated that the Facility staff discussed the Resident's case at these weekly meetings during 12 of the 14 weeks he lived in the Facility. There was no evidence that the Resident's Care Plan was amended to reflect the matters discussed during those conversations.

The Social Services Director indicated that she worked with the Resident during his stay at the Facility but failed to document her contacts with him. She emphasized that the weekly interdisciplinary team meetings at the Facility include discussions of many topics, including residents' mood and behavior, and stated that the Resident's mood was discussed at times during his stay. She indicated that she believes that the Facility's charting changed after the Resident was moved to long-term care and that the Resident's symptoms of anxiety and depression were emphasized to a greater extent

[18] MDH Ex. E-12.
[19] Facility Exs. 15 and 22.
[20] Facility Ex. 7.
[21] Facility Ex. 22.

after it was no longer expected that he would be discharged from the facility after a short-term stay. She stated that the Facility took good care of the Resident and his family was very pleased with his care.

Discussion

Applicability of Tag F 319

Tag F 319 is based upon an alleged violation of 42 C.F.R. § 483.25(f)(1). Section 483.25(f)(1) requires that a facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem based on the resident's "comprehensive assessment."[22]

As reflected in the State Operations Manual (SOM), the intent of 42 C.F.R. § 483.25 is to ensure the resident does not deteriorate within the limits of a resident's right to refuse treatment and within the limits of recognized pathology and the normal aging process. "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment. In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present: an accurate and complete assessment; a care plan which is implemented consistently and based on information from the assessment; and evaluation of the results of the interventions and revising the interventions as necessary.[23]

The Department asserts that the Facility failed to perform a comprehensive assessment of the Resident. In particular, the Department contends that MDS and RAPS issued in the May and August 2009 were insufficient because they merely recited the Resident's symptoms and failed to trigger an investigation of the underlying causes of his symptoms of anxiety, depression, and anger. In the Department's view, a more in-depth assessment that revealed the underlying causes of the symptoms is necessary to determine what interventions are most appropriate and should be incorporated in the care plan. Furthermore, the Department argues that the Facility neglected to re-assess the Resident's condition and update his Care Plan to reflect the reassessment even though he declined during June and July.

The Administrative Law Judge concludes that the F 319 tag is supported by the record and should not be rescinded. Based upon the documentation provided, it is clear that the Resident did, in fact, display mental or psychosocial adjustment difficulty during his stay at the Facility. As set forth in the Interpretive Guidelines, "mental and psychosocial adjustment difficulties" encompass difficulties that residents have in adapting to changes in life's circumstances, and are characterized by an overwhelming sense of loss, hopelessness, sad or anxious mood, or behavioral symptoms. Other manifestations include social isolation, sleep pattern disturbance, and stereotypical

[22] 42 C.F.R. § 483.25(f)(1).
[23] MDH Ex. F.

responses to stressors.[24] There was ample evidence that the Resident frequently had a depressed mood, cried, had sad facial expressions, asked why he didn't just die, said he wished that he was dead, expressed anxiety about why things had changed, was anxious, made self-deprecating comments, was angry, and was preoccupied with death. As early as late May and early June, the Resident was described as having a "flat" affect and being "very depressed." Despite the Facility's contention during the IIDR conference that the Resident's mental and psychosocial condition did not actually deteriorate between May and August, the Facility itself noted a deterioration by the time it prepared the August RAP Summary and MDS. In fact, the August MDS was triggered by a significant change in the Resident's status.

As discussed more fully below, the Facility provided a variety of assessments, treatments, and services to the Resident, and was clearly well-intentioned in its approach. However, based upon the records provided, it appears that the Facility failed to go beyond merely reciting symptoms in the assessments it performed. To be comprehensive in nature, an assessment should include sufficient testing and/or appropriate outside referrals to ensure that there is an adequate understanding of the underlying causes or triggers of those symptoms so that the most effective treatments or services are promptly identified and provided. In light of the continuing and increasing symptoms experienced by the Resident, at a minimum the Facility should have performed a Depression Scale in June or early July and, if appropriate, referred the Resident to a therapist. In addition, as time went on and the Resident's mood continued to deteriorate, the Facility failed to take prompt action to reassess the Resident and explore whether changes should be made in the Resident's Care Plan. Because the Facility failed to take prompt action to administer a Depression Scale, refer the Resident to a therapist if warranted, reassess the Resident, and make any appropriate changes in his Care Plan, it violated 42 C.F.R. § 483.25(f)(1).

Scope and Severity Level

Minn. Stat. § 144A.10, subd. 16(d)(5), specifically authorizes determinations issued in connection with IIDR proceedings to include a finding that a citation's "[s]everity [is] not supported," and permits a recommendation to be made that a citation be "amended through a change in the severity assigned to the citation." There is no language in the statute limiting such situations only to immediate jeopardy or substandard quality of care severity levels. In addition, the federal regulations set forth in 42 C.F.R. § 488.331(a) require states to offer facilities an informal opportunity "to dispute survey findings." Thus, notwithstanding CMS's informal policy statements to the contrary in the State Operations Manual and Program Letter instructions, it appears that the Department's determination that the Resident suffered actual harm is a "survey finding" that may be disputed by the Facility in this IIDR.

The Interpretive Guidelines for skilled nursing facilities defines level 3 "actual harm" deficiency determinations as follows:

[24] MDH Ex. D-2.

> Level 3 is noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.[25]

The Administrative Law Judge concludes that the severity level of G is not appropriate in this case. There is no evidence that suggests that the treatment provided by the Facility for the Resident's mood and psychosocial issues in any way caused his condition to deteriorate or that different treatment would have improved it.[26] While it is true that the Resident's assessments primarily recited his symptoms rather than exploring the underlying causes of those symptoms, the Department failed to show whether or how a more probing assessment would have changed the care provided to the Resident. The federal Interpretive Guidelines from Appendix PP of the State Operations Manual (SOM) state:

> Appropriate treatment and services for psychosocial adjustment difficulties may include providing residents with opportunities for self-governance; systematic orientation programs; arrangements to keep residents in touch with their communities, culture heritage, former lifestyle, and religious practices; and maintaining contact with friends and family. Appropriate treatment for mental adjustment difficulties may include crisis intervention services; individual, group or family psychotherapy, drug therapy and training in monitoring of drug therapy and other rehabilitative services.

Many of the treatments and services described in the Interpretive Guidelines were provided for the Resident. The Facility offers self-governance to its residents as an integral part of its care model. The Resident was in frequent touch with his community – friends, family, his priest, members of his church, and the Facility chaplain -- and his Care Plan included specific instructions for staff to assist him in contacting them.[27] The Department acknowledged that Facility employees are very caring and committed to the residents. The Resident's daughter and granddaughter each wrote letters in support of the Facility, praising the care the Resident received while at the Facility.[28] His daughter stated that the Facility staff made "every effort to stimulate" the Resident and that his "physical and spiritual needs were met." The Resident's granddaughter is employed at the Facility as a Trained Medication Aide and visited him during his stay at the Facility. She noted in her letter that she was "sure he had the best care and that all his needs were being met." Facility staff administered and

[25] MDH Ex. C-2.
[26] The survey finding that the Resident lost 8 pounds during his 3-month stay at the Facility does not support a finding of actual harm stemming from the Resident's mental or psychosocial issues, given the frequent fluctuations that occurred in his weight, his physician's prescription of diuretics and other medications, his physician's expectation that the Resident's weight would stabilize at approximately 125 pounds, and the Resident's chronic heart problems. See Facility Exs. 13, 16, 17.
[27] As a result, the implication in the Statement of Deficiencies that Facility staff somehow failed to provide proper contact with the Resident's priest was not supported by the evidence.
[28] Facility Ex. 22.

monitored his medications and sought adjustments from his physician to improve his condition, and drug therapy was at times noted to be effective.[29] The Facility also provided the Resident with reassurance and individual attention which was sometimes noted to be helpful.[30]

The Social Services Director stated that the Facility tries to work with residents who are experiencing psychosocial difficulties for several months before making a referral to an outside psychiatrist or psychologist. There are residents in the Facility who see outside providers, but the Resident's tenure at the Facility was comparatively brief for such a referral to have been made. The Department provided no evidence that the Facility's failure to delve deeper to determine underlying causes of the Resident's symptoms of anxiety and depression resulted in a negative outcome that compromised his ability to maintain or reach his highest practicable level of psychosocial well-being. The Department also did not show any likelihood that changing the treatment would have made any difference to the Resident, who was "looking forward to death" and for whom the treatment plan was "treat for comfort". The Department's arguments relating to the impact of the Facility's deficient practices on the Resident were speculative at best.

Because there was no evidence that the Resident experienced actual harm as a result of the Facility's failure to comprehensively assess him, the Administrative Law Judge concludes that a severity level of G is not warranted and recommends instead a severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy).

B. L. N.

[29] Facility Exs. 9-11.
[30] *See, e.g.,* Facility Ex. 7 (notes for July 14, 2009, and July 30, 2009).